

The Role of the States in Enhancing Capacity and Infrastructure Under the Rural Hospital Flexibility Program



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Objective of this study

- To document and explore the goals proposed by the states for their Flex Programs
- To describe the resources needed to implement these goals
- To explore the use of these resources in enhancing capacity at the state and hospital level

Methodology

- Review of Individual Flex Grant Application from all 47 participating states for the period September 1, 2001 through August 31, 2002.
- Semi-structured telephone interviews with the Flex Coordinators from each state

Goal that was substantially achieved according to the Flex Coordinators

- Designation of CAHs 43%
- Development of rural health networks 21%
- Improvement/enhancement of EMS 17%
- Quality assurance/improvement initiatives 9%
- Revision of state plan 4%
- Evaluation of Flex Program 2%
- Supporting CAHs 2%
- Reduction of surveys for CAH facilities 2%

Goal that was not fully achieved according to Flex Coordinator

- Improvement/enhancement of EMS 34%
- Development of rural health networks 19%
- Evaluation of Flex Program 13%
- Designation of CAHs 9%
- Quality assurance/improvement initiatives 9%
- Revision of state plan 6%
- Supporting CAHs 4%
- None 4%
- Supporting telecommunication capacity 2%

Networking Accomplishments

- As part of the conversion process, NH hospitals are required to prepare an Access Improvement Plan addressing opportunities to involve community based organizations around four themes:
 - Support of safety net providers
 - Support and strengthening of EMS
 - Enhancement of access to primary care providers
 - Enhancement of community efforts to improve primary care access
- CAHs are required to submit annual progress reports on these efforts

Networking accomplishments continued

- Montana has created an informal network of the Directors of Nursing in CAHs. They have held three meetings of the DONs so far with a fourth planned in July. Most DONs did not know one another. They have included educational tracks on grant programs, HIPAA, etc.
- Illinois has created a network of CAHs with four peer review groups (CEOs/CFOs, business office staff, QI staff, and nursing leaders).

Networking accomplishments continued

- South Carolina has given mini-grants to hospitals in five to six communities and provided extensive community needs assessments in 14 communities
- Tennessee worked with Regional Health Councils to identify local needs in order to distribute mini-grant funds for networking projects

Networking accomplishments continued

- Kansas has developed a toolkit to assist in network development. There are 18 rural health networks in Kansas with one in the process of being surveyed.
- North Dakota has distributed three to four grants to new CAHs to support networking activities. One group of CAHs has developed a small surgical network. Another is focused on QI initiatives.

Networking accomplishments continued

- Florida works with nine state certified rural health networks covering 29 out of 33 rural counties. The Panhandle Area Network conducts a credentialing program that is being adopted by other rural hospitals, a diabetes education program, the purchase of a mobile dental van, and the provision of support to CAHs in its service area.
- West Virginia provides TA, education, and grants to CAHs. One grant has been to a community group attempting to re-open a closed hospital as a CAH.

Key resources in the accomplishment of networking goals

- Relationships
 - Advisory committees with broad participation of key stakeholders
 - Hospital associations
 - Cooperative extensions services
 - AHECs
- History and experience
 - Town/community centered activity in NH and NC
 - Long experience with established networks (Kansas)
 - RWJ funded Rural Hospital network (Nevada)
 - State certified and funded rural health networks (FL)

Key resources in the accomplishment of networking goals

- Outside resources
 - Access to a community development employed by the state (SC)
 - Cooperative extension services (OK)
 - Regional health councils (TN)
 - AHECs
- Input and involvement of CAH staff

Key resources in the accomplishment of networking goals

- Technical assistance and facilitation to bring partners together
- The view of networking embedded as a strategy in other Flex initiatives
 - QI/QA
 - Support for rural hospitals and CAHs
 - Expansion of services and access

Key resources in the accomplishment of networking goals

- Linkages with other grant programs
 - Flex funds viewed as seed money
 - Rural Health Networking grants
 - Other foundations
 - State grant programs
- Staff resources

Resources needed by states that were unable to fully achieve networking goals

- Clear understanding of the purpose of networking
 - Some states have felt that the Flex definition of networking doesn't meet their needs
 - Networking as an activity rather than a strategy
 - Cannot use a “cookie cutter approach”
 - Clear goal of what is to be accomplished
- Staff resources

Resources needed by states that were unable to fully achieve networking goals

- Education and tools needed to employ networking strategies specific to state and/or community needs
 - Community level networking
 - Vertical networking between hospitals
 - Networking between CAHs and other rural hospitals
- Buy-in from participants

Challenge for states

- Achieving the proper balance between building internal state capacity vs. moving money to the community/hospital level
- Finding the right partners
- Achieving long term sustainability.